NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

ADMINISTRATION

PREAMBLE

1.	**Sections Affected**	**Rulemaking Action**
	R9-22-705	Amend
	R9-22-712	Amend
	R9-22-712.35	Amend
	R9-22-712.40	Amend

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. § 36-2903.01

Implementing statute: A.R.S. § 36-2903.01

3. The effective date of the rules:

The rules are effective 60 days after filing with the Secretary of State.

4. A list of all previous notices appearing in the *Register* addressing the final rules:

Notice of Rulemaking Docket Opening: 13 A.A.R. 4331, December 7, 2007

Notice of Proposed Rulemaking: 13 A.A.R. 4477, December 21, 2007

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Mariaelena Ugarte

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6. An explanation of the rule, including the agency's reasons for initiating the rule:

The Administration intends to clarify the coverage and reimbursement requirements related to hospital services provided out-of-state.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule or did not rely on in its evaluation of or justification for the rule, where the

public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

No study was reviewed during this rulemaking, however, a data analysis for out of state health plan encounters was performed.

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

The Administration anticipates minimal to no impact on small businesses or consumers with the rule changes. These changes provide clarification of how necessary medical services will be reimbursed when received out-of-state or out of the geographical service area.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

No substantive changes have been made between the proposed rules and the final rules below. The Administration made the rules more clear, concise, and understandable by making grammatical, verb tense, punctuation, and structural changes throughout the rules.

11. A summary of the comments made regarding the rule and the agency response to them:

The Administration received the following comments regarding the rules:

Date:	Commenter:	Comment:	Date of response:	Response:
01/21/08	Kimulet Winzer Compliance Officer United Healthcare	Sections R9-22-705(F) and R9-22-712(B) outline that a "contractor shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent state-wide urban cost-to-charge ratio as determined in R9-22-712.01(6)(b)". R9-22-712.01 (6)(b) references the use of the most current Medicare cost-to-charge ratios as published by CMS each year. Following this reimbursement methodology, a health plan will be exposed and subject to any changes in an Out Of State hospital's customary charges (chargemaster) without limitation, and this may cause a financial burden to health plans and the Administration. United Health Care recommends that AHCCCS consider a "fixed-rate" methodology for inpatient Out Of	02/15/08	AHCCCS Administration reviewed health plan data for out-of-state services for a one year period and determined that the fiscal impact of using the proposed Cost to Charge Ratio (CCR) methodology rather than tier reimbursement would be minimal. 1 percent would be healthplan paid days, averaging a daily rate that is within 6% of the average tier rate paid. Moreover, the AHCCCS Administration is currently

		State claims payment, such as the tiered payment methodology or a percentage of the Medicare MS-DRG reimbursement.		paying out-of-state hospital services using the CCR methodology. The cost associated with modifying the system to pay differently would be significant.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

13. Incorporations by reference and their location in the rules:

Not applicable

14. Was this rule previously adopted as an emergency rule?

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-705. Payments by Contractors

A. General requirements. A contractor shall contract with providers to provide covered services to members enrolled with the contractor. The contractor is responsible for ~~the reimbursement and coordination of care~~ reimbursing providers and coordinating care for services provided to a member. Except as provided in subsection (A)(2), a contractor is not required to reimburse a noncontracting provider for services rendered to a member enrolled with the contractor.

1. Providers. A provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904 and 42 CFR 431.107(b) as of March 6, 1992, which is incorporated by reference, ~~and~~ on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
2. A contractor shall reimburse a noncontracting provider for services rendered to a member enrolled with the contractor ~~at the Administration's capped fee-for-service schedule rate~~ as specified in this Article if:
    a. The contractor referred the member to the provider or authorized the provider to render the services and the claim is otherwise payable under this Chapter, or
    b. The service is emergent under Article 2 of this Chapter.

B. Timely submission of claims.

1. Under A.R.S. § 36-2904, a contractor shall deem a paper or electronic claim as submitted on the date that the claim is received by the contractor. The contractor shall do one or more of the following for each claim the contractor receives:
    a. Place a date stamp on the face of the claim,
    b. Assign a system-generated claim reference number, or
    c. Assign a system-generated date-specific number.

2. Unless a shorter time period is specified in subcontract, a contractor shall not pay a claim for a covered service unless the claim is initially submitted within one of the following time limits, whichever is later:
    a. Six months from the date of service or for an inpatient hospital claim, six months from the date of discharge; or
    b. Six months from the date of eligibility posting.
3. Unless a shorter time period is specified in subcontract, a contractor shall not pay a clean claim for a covered service unless the claim is submitted within one of the following time limits, whichever is later:
    a. Twelve months from the date of service or for an inpatient hospital claim, twelve months from the date of discharge; or
    b. Twelve months from the date of eligibility posting.

~~**C.** Date of claim. A contractor's date of receipt of an inpatient or an outpatient hospital claim is the date the claim is received by the contractor as indicated by the date stamp on the claim, the system-generated claim reference number, or the system-generated date-specific number assigned by the contractor. A hospital claim is considered paid on the date indicated on the disbursement check. A denied hospital claim is considered adjudicated on the date of the claim's denial. For a claim that is pending for additional supporting documentation specified in A.R.S. §§ 36-2903.01 or 36-2904, the contractor shall assign a new date of receipt upon receipt of the additional documentation. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. §§ 36-2903.01 or 36-2904, the contractor shall not assign a new date of receipt. A contractor and a hospital may, through a contract approved as specified in R9-22-715, adopt a method for identifying, tracking, and adjudicating a claim that is different from the method described in this subsection.~~

C. Date of claim.

1. A contractor's date of receipt of an inpatient or an outpatient hospital claim is the date the claim is received by the contractor as indicated by the date stamp on the claim, the system-generated claim reference number, or the system-generated date-specific number assigned by the contractor.
2. A hospital claim is considered paid on the date indicated on the disbursement check.
3. A denied hospital claim is considered adjudicated on the date of the claim's denial.
4. For a claim that is pending for additional supporting documentation specified in A.R.S. §§ 36-2903.01 or 36-2904, the contractor shall assign a new date of receipt upon receipt of the additional documentation.

5. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. §§ 36-2903.01 or 36-2904, the contractor shall not assign a new date of receipt.

6. A contractor and a hospital may, through a contract approved as specified in R9-22-715, adopt a method for identifying, tracking, and adjudicating a claim that is different from the method described in this subsection.

D. Payment for in-state inpatient hospital services. A contractor shall reimburse an in-state provider ~~and a noncontracting provider for~~ of inpatient hospital services rendered with an admission date on or after March 1, 1993, at either a rate specified by subcontract or, in absence of the subcontract, the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and this Article. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715. This subsection does not apply to an urban contractor as specified in R9-22-718 and A.R.S. § 36-2905.01.

E. Payment for in-state outpatient hospital services.

1. A contractor shall reimburse an in-state ~~provider and a noncontracting~~ provider ~~for~~ of outpatient hospital services rendered on or after March 1, 1993 through June 30, 2005, at either a rate specified by a subcontract that complies with R9-22-715(A) or, in absence of a subcontract, as described in R9-22-712 or under A.R.S. § 36-2903.01. Subcontract rates, terms, and conditions are subject to review~~,~~ and approval or disapproval~~,~~ under A.R.S. § 36-2904 and R9-22-715.

2. A contractor shall reimburse an in-state provider ~~and noncontracting provider for~~ of outpatient hospital services rendered on or after July 1, 2005, at either a rate specified by a subcontract or, in absence of a subcontract, as provided under R9-22-712.10, A.R.S. § 36-2903.01 and other sections of this Article. ~~Subcontract rates, terms, and conditions~~ The terms of the subcontract are subject to review~~,~~ and approval or disapproval~~,~~ under A.R.S. § 36-2904 and R9-22-715.

~~**F.** Inpatient and outpatient out-of-state hospital payments. A contractor shall reimburse out-of-state hospitals for covered inpatient and outpatient services and associated professional fees provided to an AHCCCS member at the lesser of the negotiated rate, or the rates as described under A.R.S. § 36-2903.01 and this Article.~~

F. Inpatient and outpatient out-of-state hospital payments. In the absence of a contract with an out-of-state hospital that specifies payment rates, a contractor shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent state-wide urban cost-to-charge ratio as determined in R9-22-712.01(6)(b). In the absence of a contract with an out-of-state hospital that specifies payment rates, a contractor

shall reimburse out-of-state hospitals for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the contractor shall pay the claim by multiplying the covered charges for the outpatient services by the state-wide outpatient cost-to-charge ratio.

G. Payment for observation days. A contractor shall reimburse a provider and a noncontracting provider for the provision of observation days at either a rate specified by subcontract or, in the absence of a subcontract, as prescribed under R9-22-712, R9-22-712.10, and R9-22-712.45. An "observation day" means a physician-ordered evaluation period of less than 24 hours to determine the need of treatment or the need for admission as an inpatient.

H. Review of claims and coverage for hospital supplies.

1. A contractor may conduct a review of any claims submitted and recoup any payments made in error.
2. A hospital shall obtain prior authorization from the appropriate contractor for nonemergency admissions. When issuing prior authorization, a contractor shall consider the medical necessity of the service, and the availability and cost effectiveness of an alternative treatment. Failure to obtain prior authorization when required is cause for nonpayment or denial of a claim. A contractor shall not require prior authorization for medically necessary services provided during any prior period for which the contractor is responsible. If a contractor and a hospital agree to a subcontract, the parties shall abide by the terms of the subcontract regarding utilization control activities. A hospital shall cooperate with a contractor's reasonable activities necessary to perform concurrent review and shall make the hospital's medical records pertaining to a member enrolled with a contractor available for review.
3. Regardless of prior authorization or concurrent review activities, a contractor may make prepayment or post payment review of all claims, including but not limited to a hospital claim. A contractor may recoup an erroneously paid claim. If prior authorization was given for a specific level of care, but medical review of a claim indicates that a different level of care was medically appropriate, a contractor shall adjust the claim to pay for the cost for the appropriate level of care. An adjustment in payment for a different level of care is effective on the date when the different level of care is medically appropriate.
4. A contractor and a hospital may enter into a subcontract that includes hospital claims review criteria and procedures if the subcontract meets the requirements of R9-22-715.
5. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:

a. Patient care kit,

b. Toothbrush,

c. Toothpaste,

d. Petroleum jelly,

e. Deodorant,

f. Septi soap,

g. Razor ~~or disposable razor~~,

h. Shaving cream,

i. Slippers,

j. Mouthwash,

k. Disposable razor,

l. Shampoo,

m. Powder,

n. Lotion,

o. Comb, and

p. Patient gown.

6. The following hospital supplies and equipment, if medically necessary and used by the member, are covered services:

a. Arm board,

b. Diaper,

c. Underpad,

d. Special mattress and special bed,

e. Gloves,

f. Wrist restraint,

g. Limb holder,

h. Disposable item used instead of a durable item,

i. Universal precaution,

j. Stat charge, and

k. Portable charge.

7. The contractor shall determine in a hospital claims review whether services rendered were:

a. Covered services as defined in R9-22-102;

b. Medically necessary;

c. Provided in the most appropriate, cost-effective, and least restrictive setting; and

d. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2904.

8. If a contractor adjudicates a claim or recoups payment for a claim, a person may file a claim dispute challenging the adjudication or recoupment as described under 9 A.A.C. 34.

I. Non-hospital claims. A contractor shall pay claims for non-hospital services in accordance with contract, or in the absence of a contract, at a rate not less than the Administration's capped fee-for-service schedule or at a lower rate if negotiated between the two parties.

J. Payments to hospitals. A contractor shall pay for inpatient hospital admissions and outpatient hospital services rendered on or after March 1, 1993, as follows and as described in A.R.S. § 36-2904:

1. If the hospital bill is paid within 30 days from the date of receipt, the claim is paid at 99 percent of the rate.
2. If the hospital bill is paid between 30 and 60 days from the date of receipt, the claim is paid at 100 percent of the rate.
3. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent of the rate plus a ~~fee of~~ 1 percent penalty of the rate for each month or portion of the month following the 60th day of receipt of the bill until date of payment.

K. Interest payment. In addition to the requirements in subsection (J), a contractor shall pay interest for late claims as defined by contract.

R9-22-712. Reimbursement: General

A. Inpatient and outpatient discounts and penalties. If a claim is pended for additional documentation required under A.R.S. § 36-2903.01(H)(4), the period during which the claim is pended is not used in the calculation of the quick-pay discounts and slow-pay penalties under A.R.S. § 36-2903.01(H)(5).

~~**B.** Inpatient and outpatient out-of-state hospital payments. AHCCCS shall reimburse out-of-state hospitals for covered inpatient and outpatient services provided to a member at the lesser of the negotiated rate or the AHCCCS FFS rate as described in A.R.S. § 36-2903.01 and this Article.~~

B. Inpatient and outpatient out-of-state hospital payments. In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent state-wide urban cost-to-charge ratio as determined in R9-22-712.01(6)(b). In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS shall reimburse an out-of-state hospital for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the Administration shall pay the claim by multiplying the covered charges for the outpatient services by the state-wide outpatient cost-to-charge ratio.

C. Access to records. Subcontracting and noncontracting providers of outpatient or inpatient hospital services shall allow the Administration access to medical records regarding eligible persons and shall in all other ways fully cooperate with the Administration or the Administration's designated representative in performance of the Administration's utilization control activities. The Administration shall deny a claim for failure to cooperate.

D. Prior authorization. The Administration shall deny a claim for failure to obtain prior authorization as required in R9-22-210.

E. Review of claims. Regardless of prior authorization or concurrent review activities, the Administration may subject all hospital claims, including outliers, to prepayment medical review or post-payment review, or both. The Administration shall conduct post-payment reviews consistent with A.R.S. § 36-2903.01 and may recoup erroneously paid claims. If prior authorization was given for a specific level of care but medical review of the claim indicates that a different level of care was appropriate, the Administration may adjust the claim to reflect the more appropriate level of care, effective on the date when the different level of care was medically appropriate.

F. Claim receipt.

1. The Administration's date of receipt of inpatient or outpatient hospital claims is the date the claim is received by the Administration as indicated by the date stamp on the claim and the system-generated claim reference number or system-generated date-specific number.
2. Hospital claims are considered paid on the date indicated on disbursement checks.

3. ~~Denied claims are~~ A denied claim is considered adjudicated on the date ~~of their denial~~ the claim is denied.

4. Claims that are denied and are resubmitted are assigned new receipt dates.

5. For a claim that is pending for additional supporting documentation specified in A.R.S. §§ 36-2903.01 or 36-2904, the Administration shall assign a new date of receipt upon receipt of the additional documentation.

6. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. §§ 36-2903.01 or 36-2904, the Administration shall not assign a new date of receipt.

G. Outpatient hospital reimbursement. The Administration shall pay for covered outpatient hospital services provided to eligible persons with dates of service from March 1, 1993 through June 30, 2005, at the AHCCCS outpatient hospital cost-to-charge ratio, multiplied by the amount of the covered charges.

1. Computation of outpatient hospital reimbursement. The Administration shall compute the cost-to-charge ratio on a hospital-specific basis by determining the covered charges and costs associated with treating eligible persons in an outpatient setting at each hospital. Outpatient operating and capital costs are included in the computation but outpatient medical education costs that are included in the inpatient medical education component are excluded. To calculate the outpatient hospital cost-to-charge ratio annually for each hospital, the Administration shall use each hospital's Medicare Cost Reports and a database consisting of outpatient hospital claims paid and encounters processed by the Administration for each hospital, subjecting both to the data requirements specified in R9-22-712.01. The Administration shall use the following methodology to establish the outpatient hospital cost-to-charge ratios:

   a. Cost-to-charge ratios. The Administration shall calculate the costs of the claims and encounters for outpatient hospital services by multiplying the ancillary line item cost-to-charge ratios by the covered charges for corresponding revenue codes on the claims and encounters. Each hospital shall provide the Administration with information on how the revenue codes used by the hospital to categorize charges on claims and encounters correspond to the ancillary line items on the hospital's Medicare Cost Report. The Administration shall then compute the overall outpatient hospital cost-to-charge ratio for each hospital by taking the average of the ancillary line items cost-to-charge ratios for each revenue code weighted by the covered charges.

   b. Cost-to-charge limit. To comply with 42 CFR 447.325, the Administration may limit cost-to-charge ratios to 1.00 for each ancillary line item from the Medicare Cost Report. The Administration shall remove

ancillary line items that are non-covered or not applicable to outpatient hospital services from the Medicare Cost Report data for purposes of computing the overall outpatient hospital cost-to-charge ratio.

2. New hospitals. The Administration shall reimburse new hospitals at the weighted statewide average outpatient hospital cost-to-charge ratio multiplied by covered charges. The Administration shall continue to use the statewide average outpatient hospital cost-to-charge ratio for a new hospital until the Administration rebases the outpatient hospital cost-to-charge ratios and the new hospital has a Medicare Cost Report for the fiscal year being used in the rebasing.
3. Specialty outpatient services. The Administration may negotiate, at any time, reimbursement rates for outpatient hospital services in a specialty facility. ~~For purposes of this subsection, "specialty facility" means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.~~
4. Reimbursement requirements. To receive payment from the Administration, a hospital shall submit claims that are legible, accurate, error free, and have a covered charge greater than 0. The Administration shall not reimburse hospitals for emergency room treatment, observation hours or days, or other outpatient hospital services performed on an outpatient basis, if the eligible person is admitted as an inpatient to the same hospital directly from the emergency room, observation area, or other outpatient department. Services provided in the emergency room, observation area, and other outpatient hospital services provided before the hospital admission are included in the tiered per diem payment.
5. Rebasing. The Administration shall rebase the outpatient hospital cost-to-charge ratios at least every four years but no more than once a year using updated Medicare Cost Reports and claim and encounter data.
6. If a hospital files an increase in its charge master for an existing outpatient service provided on or after July 1, 2004, and on or before June 30, 2005, which represents an aggregate increase in charges of more than 4.7 percent, the Administration shall adjust the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through (G)(5) by applying the following formula:

CCR*[1.047/(1+ % increase)]

Where "CCR" means the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through (G)(5) and "% increase" means the aggregate percentage increase in charges for outpatient services shown on the hospital charge master.

"Charge master" means the schedule of rates and charges as described under A.R.S. § 36-436 and the rules that relate to those rates and charges that are filed with the Director of the Arizona Department of Health Services.

~~"Existing outpatient services" means a service provided by the hospital prior to the hospital filing an increase in its charge master, regardless of whether the service was explicitly described in the hospital charge master before filing the increase, or how the service was described in the charge master before filing the increase.~~

R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees

A. AHCCCS shall increase the ~~fees~~ outpatient capped-fee-schedule established under R9-22-712.20 (except for laboratory services and out-of-state hospital services) for the following hospitals submitting any claims:

1. By 48 percent for public hospitals on July 1, 2005, as well as hospitals that were public ~~in~~ anytime during the calendar year 2004~~.~~;
2. By 45 percent for hospitals in counties other than Maricopa and Pima with more than 100 Medicare PPS beds during the contract year in which the outpatient capped-fee-schedule rates are effective~~.~~;
3. By 50 percent for hospitals in counties other than Maricopa and Pima with 100 or less Medicare PPS beds during the contract year in which the outpatient capped-fee-schedule rates are effective~~.~~;
4. By 115 percent for hospitals designated as Critical Access Hospitals, or for hospitals that have not been designated as Critical Access Hospitals, but meet the criteria~~.~~ during the contract year in which the outpatient capped-fee-schedule rates are effective;
5. By 113 percent for a freestanding children's hospital with at least 110 pediatric beds~~.~~ during the contract year in which the outpatient capped-fee-schedule rates are effective; or
6. By 14 percent for a University Affiliated Hospital ~~defined as those hospitals that have~~ , which is a hospital that has a majority of the ~~member~~ members of its board of directors appointed by the Board of Regents during the contract year in which the outpatient capped-fee-schedule rates are effective.

B. In addition to subsection (A), the following outpatient capped-fee-schedule rate increase ~~may be~~ shall be established: A 50 percent adjustment for a Level 2 and 3 emergency department procedures billed by a ~~level~~ Level 1 ~~Trauma~~ trauma center as defined by R9-22-2101.

C. Fee adjustments ~~in~~ made under subsection (A) and (B) are available with the AHCCCS Outpatient Capped Fee-For Service Schedule, which is on file ~~and online~~ with AHCCCS and posted on AHCCCS' website.

R9-22-712.40. Outpatient Hospital Reimbursement: Annual and Periodic Update

A. Procedure ~~Codes~~ codes. When procedure codes are issued by CMS and added to the Current Procedural Terminology published by the American Medical Association, AHCCCS shall add the new procedure codes for covered outpatient services and shall either assign the default CCR, the Medicare rate, or calculate an appropriate fee ~~when procedure codes are issued by CMS or the Current Procedural Terminology published by the American Medical Association~~.

B. APC ~~Changes~~ changes. AHCCCS may reassign procedure codes to new or different APC groups when APC groups are revised by ~~Medicare~~ CMS. AHCCCS may reassign procedure codes to a different APC group than Medicare. If AHCCCS determines that utilization of ~~the~~ a procedure code within the Medicare program is substantially different from utilization of the procedure code in the AHCCCS program, AHCCCS may chose not to assign the procedure code to any APC group. For procedure codes not grouped into an APC by Medicare, AHCCCS may assign the code to an APC group when AHCCCS determines that the cost and resources associated with the non-assigned code are substantially similar to those in ~~a particular~~ the APC group.

C. Annual ~~Update~~ update for Outpatient Hospital Fee Schedule. Beginning October 1, 2006, AHCCCS shall adjust outpatient fee schedule rates:

1. ~~On an annual basis~~ Annually by multiplying the rates effective during the prior year by the Global Insight Prospective Hospital Market Basket Inflation Index; or
2. In ~~any given~~ a particular year the director may substitute the increases in ~~(B)(1)~~ (C)(1) by calculating the dollar value associated with the ~~inflationary increase in (B)(1)~~ inflation index in (C)(1), and applying ~~that~~ the dollar value to adjust rates at varying levels.

D. Rebase. AHCCCS shall rebase the outpatient fees every five years.

E. Statewide CCR. The statewide CCR calculated in R9-22-712.30 shall be recalculated at the time of rebasing~~,~~. ~~at which time~~ When rebasing, AHCCCS may consider recalculating the statewide CCR based on the costs and charges for ~~those~~ services excluded from the outpatient hospital fee schedule.